88-1546

No. ———

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,
Petitioners,

v.

HARRIETTE TURNBOW,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEVADA

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QUESTIONS PRESENTED

1. Whether, under the Employee Retirement Income Security Act ("ERISA"), an employer has established or maintained an "employee welfare benefit plan" by obtaining, and paying premiums for, a group health care plan with funding and claims-administration provided by an insurance company (thereby satisfying the Department of Labor regulations defining the employer involvement necessary to "establish" an insured plan).

2. Whether a working owner, partner or sole proprietor who, along with one or more common law employees, is covered by an ERISA-regulated plan and is eligible to receive benefits, is considered a "participant" or "beneficiary" for purposes of ERISA's civil enforcement provisions so that such individual's suit to recover benefits and redress breaches of fiduciary duties is governed by ERISA rather than by state law doctrines, including punitive damages.

PARTIES TO THE PROCEEDING

PACIFIC MUTUAL LIFE INSURANCE COMPANY*

BENEFICIAL ADMINISTRATION COMPANY**

PENSION ADMINISTRATION, INC.

JOHN F. McGOWAN

DONALD R. LAWRENZ, individually, and as Trustee of Beneficial Employees Security Trust

BENEFICIAL EMPLOYEES SECURITY TRUST

HARRIETTE TURNBOW

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* The following are non-wholly owned subsidiaries of Pacific Mutual Life Insurance Company as well as companies that may be deemed affiliates thereof:

United Planners Group, Inc.
United Planners Financial Services of America
Employee Benefits America Administration Corp.

** The following are non-wholly owned subsidiaries of Beneficial Administration Company as well as companies that may be deemed affiliates thereof:

Beneficial Employees Security Trust
Pension Administrators, Inc.
BEST Employers Association, Inc.
BEST Pro-Tek, Inc.
BEST Benefit Payments, Inc.
BEST Employee Benefit Administrators, Inc.
BEST Life Insurance Company of California

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
PARTIES TO THE PROCEEDING	ii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTIONAL STATEMENT	2
STATUTES AND REGULATIONS INVOLVED	2
STATEMENT OF THE CASE	2
A. The Facts	3
B. The Trial Court Granted Summary Judgment Based On ERISA Coverage And Preemption	6
C. Reversal By The Nevada Supreme Court	7
D. Finality of Decision	8
REASONS FOR GRANTING THE WRIT	8
I. The Nevada Supreme Court's Decision Conflicts With Congress' Express Directive That ERISA Uniformly Encompass All Employee Welfare Benefit Plans, Self-Funded And Insured Alike, Preempting Parallel State Law Claims	8
A. Congress Deliberately Adopted An Expansive Definition Of Employee Welfare Benefit Plan Which The State Court Intentionally Overturned	11
B. The State Court Decision, By Mandating A Long-Term Duration Requirement, Imposes An Illogical And Unworkable Coverage Standard Which Conflicts With ERISA's Uniform Coverage Provisions	14

TABLE OF CONTENTS—Continued

Page

II. The Nevada Supreme Court's Decision, Which Conflicts With The Decisions Of Three Circuits, Reflects An Increasingly Significant Circuit Split, And Wide-Spread Division And Error In The Lower Courts, Which Can Only Be Resolved By This Court 16

III. The Nevada Supreme Court's Decision Takes An Intentional Step Backward From Pilot Life, Reopening A Door To Punitive Damages And Raising Financial Disincentives To Insured Plans Contrary To Congressional Intent 20

IV. The Court's Alternative Holding That Working Owners Are Not Participants Or Beneficiaries For Purposes Of ERISA's Civil Enforcement Provisions Creates A Serious Dysfunction In The Statute, And Will Lead To The "Mutually Exclusive Pockets Of Federal And State Jurisdiction Within A Plan" Warned Against By This Court 21

V. The Questions Presented By This Petition Hold Important Implications For Employee Welfare Benefit Plans That Should Be Resolved By This Court 26

CONCLUSION 28

TABLE OF AUTHORITIES

CASES Page

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) 8
Anschultz v. Connecticut General Life Ins. Co., 850 F.2d 1467 (11th Cir. 1988) 10
Batterton v. Francis, 432 U.S. 416 (1977) 12
Belasco v. W.K.P. Wilson & Sons, Inc., 833 F.2d 277 (11th Cir. 1987) 17
Blau v. Del Monte Corp., 748 F.2d 1348 (9th Cir. 1984) (as amended in 1985), *cert. denied*, 474 U.S. 865 (1985) 11
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Chemical Manufacturers Ass'n v. National Resources Defense Council, Inc., 470 U.S. 116 (1985) 12
Commercial Life Ins. Co. v. Superior Court, 47 Cal. 3d 473 (1988) 10
Credit Managers Ass'n v. Kennesaw Life and Acc. Ins. Co., 809 F.2d 617 (9th Cir. 1987) 18
Dodd v. John Hancock Mutual Life Ins. Co., 688 F.Supp. 564 (E.D. Cal. 1988) 23, 24
Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) (*en banc*) 12, 17
Ed Miniat, Inc. v. Globe Life Ins. Group, Inc., 805 F.2d 732 (7th Cir. 1986), *cert. denied*, 107 S. Ct. 3188 (1987) 23
Firestone Tire and Rubber Co. v. Bruch, 57 U.S.L.W. 4194 (1989) 25
Fort Halifax Packing Co. v. Coyne, 107 S. Ct. 2211 (1987) 8, 15, 20, 25, 26
Giardono v. Jones (1989 U.S. App. LEXIS 1499) (7th Cir. 1989) 23
Holland v. Burlington Industries, Inc., 772 F.2d 1140 (4th Cir. 1985), *summarily aff'd*, 477 U.S. 901 (1986) 10
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TABLE OF AUTHORITIES—Continued

Page

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LeFebre v. Westinghouse Electric Corp., 747 F.2d 197 (4th Cir. 1984) 13
Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) 20
Nachman Corp. v. Pension Benefit Guaranty Corp., 446 U.S. 359 (1980) 8
Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) ..... *passim*
Pitre v. Louisiana Health Service and Indemnity Co., 122 F.R.D. 497 (W.D. La. 1988) 18, 24
Rizzi v. Blue Cross of Southern California, 206 Cal.App.3d 380 (1988) 19
Roe v. General American Life Ins. Co., 712 F.2d 450 (10th Cir. 1983) 17
Sayble v. Blue Cross of Southern California, 207 Cal.App.3d 953 (1989) (reh. granted) 18
Schulist v. Blue Cross, 553 F.Supp. 248 (N.D. Ill. 1982), *aff'd*, 712 F.2d 1127 (7th Cir. 1983) 13
Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) ..... *passim*
Shiffler v. Equitable Life Assur. Soc. of U.S., 838 F.2d 78 (3d Cir. 1988) 18
Taggart Corp. v. Life & Health Benefits Admin. Inc., 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981) 16, 17, 18, 19
Wadsworth v. Whaland, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) 9
Wayne Chemical, Inc. v. Columbus Agency Service Corp., 567 F.2d 692 (7th Cir. 1977) 17

STATUTES

ERISA section 2(a), 29 U.S.C. § 1001(a) 9, 21
ERISA section 3(1), 29 U.S.C. § 1002(1) ..... *passim*
ERISA section 3(7), 29 U.S.C. § 1002(7) 2, 22, 23
ERISA section 3(8), 29 U.S.C. § 1002(8) 2, 22

TABLE OF AUTHORITIES—Continued

Page

ERISA section 3(14)(B), 29 U.S.C. § 1002(14)(B) 5
ERISA section 3(16)(A), 29 U.S.C. § 1002(16)(A) 13, 15
ERISA section 4(a)(1), 29 U.S.C. § 1103(a)(1) 6
ERISA section 404(a)(1), 29 U.S.C. § 1104(a)(1) 5, 9, 14
ERISA section 406(a), 29 U.S.C. § 1106(a) 5
ERISA section 408(b)(2), 29 U.S.C. § 1108(b)(2) 5
ERISA section 502(a), 29 U.S.C. § 1132(a) 2, 5, 6, 10, 14
ERISA section 502(e)(1), 29 U.S.C. § 1132(e)(1) 9, 14
ERISA section 503, 29 U.S.C. § 1133 ..... 13, 14, 20
ERISA section 505, 29 U.S.C. § 1135 ..... 2, 12
ERISA section 514(a), 29 U.S.C. § 1144(a) 2, 6, 10
Internal Revenue Code, Section 89, 26 U.S.C. § 89 ..... 14, 22, 23
28 U.S.C. § 1257(a) 1, 8
Consolidated Omnibus Budget Reconciliation Act of 1985 ..... 22, 23
Tax Equity and Fiscal Responsibility Act of 1987 25
Nevada Revised Statutes, Chapter 686A 5

REGULATIONS

29 C.F.R. § 2510.3-1(j) (1987) 2, 6, 12
29 C.F.R. § 2510.3-3(b) (1987) 21, 23
29 C.F.R. § 2560.503-1(g)(2) (1987) 2, 13, 15
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Proposed Treas. Reg. § 1.61-1 Q & A 16 (1987) 23
Nevada Admin. Code § 686A 5

CONGRESSIONAL MATERIALS

Introductory statement of Senator Javits on S. 1557, *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974, 279 (1976) 9

TABLE OF AUTHORITIES—Continued

Page

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120 Cong. Rec. 29,933 (1974) (remarks of Sen. Williams) 9
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MISCELLANEOUS

Administration of the Employee Retirement Income Security Act, Calendar Year 1987, Report of the Secretary of Labor to Congress 26
Amicus brief filed by the Solicitor General in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987)..... 21
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DOL Opinion Letter 80-10A 12
DOL Opinion Letter 81-54A 23
DOL Opinion Letter 81-73A 12
DOL Opinion Letter 81-84A 12

TABLE OF AUTHORITIES—Continued

	Page
DOL Opinion Letter 82-059A	12
DOL Reporting and Disclosure Regulations, 40 Fed. Reg. 34528	23
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HARRIETTE TURNBOW,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEVADA

The Petitioners, Pacific Mutual Life Insurance Company, Beneficial Administration Company, Pension Administration, Inc., Donald R. Lawrenz, individually and as Trustee for Beneficial Employees Security Trust, and Beneficial Employees Security Trust, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the Supreme Court of Nevada entered in this proceeding on December 21, 1988.

OPINIONS BELOW

The Petition seeks review of a judgment and opinion of the Supreme Court of Nevada reported at 104 Nev. Adv.Op. 109 (1988), and which appears in the Appendix ("App.") at 1a to 5a. The judgment and opinion, and later amendment *nunc pro tunc*, of the First Judicial District Court of Nevada are unreported and appear in the Appendix at 6a to 8a.

JURISDICTIONAL STATEMENT

The judgment and opinion of the Nevada Supreme Court was entered on December 21, 1988. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

STATUTES AND REGULATIONS INVOLVED

This case involves sections 3(1), 3(7), 3(8), 502(a), 505 and 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1002(1), 1002(7), 1002(8), 1132(a), 1135 and 1144 (a), and 29 C.F.R. §§ 2510.3-1(j) and 2560.503-1(g)(2) (1987) promulgated under ERISA section 505. These provisions are reproduced in the Appendix at 9a to 12a.

STATEMENT OF THE CASE

The Nevada Supreme Court has ruled restrictively on two major, unresolved ERISA coverage and preemption issues. Reflecting a sharp conflict among at least five Circuits, the court held that a garden variety insured employee welfare benefit plan—identical to the overwhelming majority of American health care plans—is not considered "established or maintained" by an employer, and therefore is not subject to ERISA's coverage and preemption provisions. The court so ruled even though the employer had obtained and paid premiums for a group insurance plan, thereby satisfying the statutory definition of "employee welfare benefit plan" and the Department of Labor regulations. Alternatively, the court held that even assuming the plan is ERISA-regulated, a working owner who, along with one or more common law employees, is covered by the plan and is eligible to receive benefits, is not a "participant" or "beneficiary" for purposes of ERISA's civil enforcement provisions. Creating a serious dysfunction between ERISA's civil enforcement scheme and all of its other regulatory provisions which cover such individual, the court ruled that a suit by that individual to recover plan benefits and redress breaches of fiduciary duties is not governed by ERISA but rather by conflicting state law doctrines, including punitive damages.

A. The Facts

In the early 1970's, Petitioners Pacific Mutual Life Insurance Company ("Pacific Mutual"), as insurer, and Beneficial Employees Security Trust ("B.E.S.T."), a multiple employer trust, entered into an agreement by which Pacific Mutual issued to B.E.S.T. a Master Policy providing group health insurance. B.E.S.T. then offered the group insurance coverage to employers with small businesses, nationwide, as a funding vehicle for their individual employee welfare benefit plans.

B.E.S.T. itself, as a multiple employer trust ("MET"), was not "established or maintained" by an employer, and thus was not an employee welfare benefit plan as defined in ERISA section 3(1), 29 U.S.C. § 1002(1). Individual private sector employers subscribing to B.E.S.T., however, used the Master Policy as a funding vehicle to establish separate, single-employer ERISA plans at favorable rates otherwise available only to larger employers. These employers also obtained a professionally-run administrative program. The plan administrator, Petitioner Beneficial Administration Company, handled billings, collections, commissions, and payment of premiums to Pacific Mutual; it was also responsible for compliance with ERISA's reporting and disclosure requirements. Pacific Mutual performed initial claims-handling, paid approved claims, and served as ERISA claims review fiduciary.

In November, 1974, The Bottle Stop, a retail liquor store in Nevada, selected through its insurance agent the "American Series Plan," one of several benefit programs available under the Master Policy, in order to fund a health care plan. The "American Series Plan" summary plan description defined the term "eligible employees" as including: "all active full-time permanent employees regularly working the firm's normal work week (30 hours or more per week). Partners or Owners are considered 'employees' for the purpose of this Plan

if they meet eligibility rules." The Bottle Stop's application listed four individuals as full-time "employees," including Respondent Harriette Turnbow ("Turnbow"). A sole proprietor, Turnbow not only managed the store, but worked alongside three common law employees including her daughter. The Bottle Stop paid all insurance premiums each month from its company account. It also participated in the plan's administration by obtaining enrollment cards from all four individuals, having its insurance agent explain the coverage to the participants, and by paying an enrollment fee and monthly service charges.

Pacific Mutual issued "American Series Plan" certificate booklets to the four plan participants, including Turnbow. Advising that the "American Series Plan" was governed by ERISA, the booklets contained an ERISA summary plan description which covered all information required by ERISA including (1) the name of the plan, (2) the plan identification number, (3) the type of administration and type of welfare plan, (4) the plan administrator,[1] (5) the agent for service of process, (6) the plan trustee, (7) the source of plan contributions, (8) the claims procedures, including the ERISA review procedure for denied claims, and (8) a "Statement of ERISA Rights."

In August of 1981, Turnbow suffered a stroke and became totally disabled. After she applied for benefits under the "American Series Plan," Pacific Mutual paid her medical benefits for a number of years. The Bottle Stop maintained its group insurance coverage from November, 1974 until May of 1983, when it requested termination because of premium increases. Pursuant to an extension of benefits period, Turnbow received benefits

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[1] As designated plan administrator, Beneficial Administration Company filed an annual Return/Report of Employee Benefit Plan (Form 5500), in accordance with ERISA, for the years that The Bottle Stop maintained coverage under the "American Series Plan."

until April of 1984. Turnbow submitted no additional claims, nor did she request a conversion policy.

On April 27, 1987, Turnbow filed her First Amended Complaint in the First Judicial District Court of Nevada. It alleged, in essence, that at the time of disability, Turnbow had a "vested" right to a "contractually set maximum" $1,000,000 benefit under the "American Series Plan," and moreover that the coverage was cancelled only because a conspiracy among Petitioners had raised the premiums to such an excessive degree (from approximately $200 per month to over $1,250) that The Bottle Stop was forced to terminate coverage.

ERISA's civil enforcement provisions, ERISA section 502(a), 29 U.S.C. § 1132(a), supply an exclusive federal remedy for failure to pay benefits due under an employee welfare benefit plan. As fiduciaries or service providers, Pacific Mutual, B.E.S.T., Beneficial Administration Company and Lawrenz [2] admittedly were "parties in interest" as defined by ERISA.[3] Excessive charges and premiums under the "American Series Plan" would violate ERISA's fiduciary responsibility and prohibited transaction rules for which ERISA supplies both an exclusive federal remedy and exclusive federal court jurisdiction.[4]

Rather than pursuing any of the ERISA claims available to her, Turnbow made only state law claims for breach of contract to pay the "contractually set maximum" $1,000,000 benefit, breach of an implied covenant, violation of Nevada revised statutes, Chapter 686A, and Nevada Administrative Code, 686A, conspiracy, fraud and negligence, and sought plan benefits, emotional distress damages and punitive damages.

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[2] Petitioner Donald R. Lawrenz served as trustee of B.E.S.T.

[3] ERISA section 3(14)(B), 29 U.S.C. § 1002(14)(B).

[4] ERISA sections 404(a)(1), 406(a), 408(b)(2), 502(a), (e)(1), 29 U.S.C. §§ 1104(a)(1), 1106(a), 1108(b)(3) and 1132(a), (e)(1).

B. The Trial Court Granted Summary Judgment Based On ERISA Coverage And Preemption

On May 28, 1987, Petitioners filed a Motion to Dismiss, supported by affidavit, in the First Judicial District Court asserting ERISA coverage based on the Act's definition of "employee welfare benefit plan" as including "*any* [health care] plan, fund, or program . . . established or maintained by an employer . . . *through the purchase of insurance or otherwise* . . ." (emphasis added). ERISA section 3(1), 29 U.S.C. § 1002(1).[5] It also asserted ERISA preemption based on the Act's preemption and civil enforcement clauses in sections 514 (a) and 502(a), 29 U.S.C. § 1144(a) and 1132(a), and this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

By order granting summary judgment, the court upheld ERISA coverage and preemption. Applying the statutory definition and Department of Labor criteria, 29 C.F.R. § 2510.3-1(j) (1987), the court held that The Bottle Stop had established an ERISA-covered plan.[6] Furthermore, it held that ERISA preempted all of Turnbow's state law causes of action and entered summary

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[5] The ERISA jurisdictional section, section 4(a)(1), 29 U.S.C. § 1003(a)(1), states that the statute covers any employee benefit plan established or maintained by an employer "engaged in commerce or in any industry or activity affecting commerce." The liquor industry in which The Bottle Stop was engaged is, beyond question, an industry or activity affecting interstate commerce.

[6] For a group insurance plan to be ERISA-covered, the court held that at least one of four criteria for employer-involvement set forth in the regulations must be met. The court found that because the "American Series Plan" was applied for, and issued, under The Bottle Stop's name, the employer endorsed, and did not merely "advertise," the plan. It also found that the employer paid all the premiums through a company account. In addition, it found that the employer procured the "Plan" for all individuals listed as full-time employees, including Turnbow; thus, employee participation was automatic. App. at 6a-8a.

judgment without prejudice, apparently to protect her right to pursue ERISA remedies. App. at 7a.

C. Reversal By The Nevada Supreme Court

On appeal, the Nevada Supreme Court, acknowledging a Circuit conflict, reversed the summary judgment order. It held that to create a non-collectively bargained ERISA plan, an employer must demonstrate that it is "committed to the continuance" of the plan by maintaining it for a substantial span of years, presumably in excess of a decade. It held, therefore, that The Bottle Stop, which had cancelled its insurance coverage for reasons of business necessity after approximately eight and one-half years, had never established an ERISA plan. Alternatively, it held that even if The Bottle Shop had established such a plan, ERISA did not preempt Turnbow's claims, including those to plan benefits. It ruled that Turnbow was not a "participant" or "beneficiary," and therefore her claims were governed by state law rather than by ERISA's civil enforcement provisions. App. at 1a-5a. The court reached these conclusions, which conflict with those of three Circuits, notwithstanding that (a) ERISA section 3(1) broadly defines "employee welfare benefit plan" as including "any plan" established "through the purchase of insurance or otherwise", and Congress intended that even this "coverage . . . be construed liberally," Senate Rep. No. 93-127 (1973), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4854; (b) the practical effect of the court's decision will be to resurrect state law as the principal mechanism for regulating employee welfare benefit plans, despite congressional intent that plan regulation be "exclusively a federal concern," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987), and to reopen a door to punitive damages closed by this Court in *Pilot Life*, *supra*, thus raising substantial economic disincentives to insured plans; and (c) the exclusion from ERISA's civil enforcement scheme of the working self-employed, de-

spite their participation in ERISA plans and eligibility to receive benefits, will create a serious dysfunction in ERISA which includes these individuals in all of its other regulatory provisions, and cause the "mutually exclusive pockets of federal and state jurisdiction within a plan," and "conflicting and inconsistent State and local regulation," against which this Court warned in *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2217 (1987) and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99, 107-08 (1983).

D. Finality Of Decision

The Nevada Supreme Court judgment and opinion on ERISA coverage and preemption is the law of the case and final for purposes of 28 U.S.C. § 1257.

REASONS FOR GRANTING THE WRIT

I. The Nevada Supreme Court's Decision Conflicts With Congress' Express Directive That ERISA Uniformly Encompass All Employee Welfare Benefit Plans, Self-Funded And Insured Alike, Preempting Parallel State Law Claims.

Review of the Nevada Supreme Court's decision is essential to restore Congress' express directive that ERISA uniformly encompass *all* employee welfare benefit plans, self-funded and insured alike, and preempt all state law claims relating to their administration. The state high court decision intentionally frustrates these congressional goals in all respects.

ERISA is a "comprehensive and reticulated statute," *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361-62 (1980), designed to make the regulation of employee benefit plans "exclusively a federal concern," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). ERISA, moreover, is built on the premise that employers should be encouraged to

provide financially *stable* employee benefit plans, *see*, ERISA section 2(a), 29 U.S.C. § 1001(a); and Congress recognized that cost-effective group insurance was essential to this goal, *see also, Employee Security Benefit Act of 1974: Material Explaining H.R. 12906*, 120 Cong.Rec. 3977, 3981-82 (1974); *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) (Congress recognized that insurance was the most common source of plan funding). Indeed, insured health care plans are not only the most stable type of plan, but often the *only* type realistically available for small and medium sized employers.[7]

In enacting ERISA, Congress also sought to replace the conflicting system of state and local regulation with "a *uniform* source of law for evaluating . . . fiduciary conduct," thereby ensuring "national uniformity" in the administration of both self-funded and insured plans (emphasis added). *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 n. 20 (1983); Introductory statement of Senator Javits on S. 1557, *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974, 273, 279 (1976); *see also* 120 Cong. Rec, 29,928, 29,933 (1974) (remarks of Sen. Williams); 29,192, 29,197 (remarks of Rep. Dent). To establish federal preeminence, Congress enacted a detailed set of standards and duties to guide fiduciaries, and also vested the federal courts with *exclusive* jurisdiction over suits alleging a breach of these duties. ERISA sections 404(a)-412, 502(e)(1), 29 U.S.C. §§ 1104(a)-1112, 1132(e)(1).

To ensure that state law would not intrude in plan administration, Congress armed ERISA with a general preemption clause of "unparalleled breadth." ERISA sec-

[7] Battelle Human Affairs Research Centers, *Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States*, 1978-79, Vol. IV, 25, 28, 37-38 (*"Battelle Study"*). A single adverse experience can bankrupt a self-funded plan for all but the largest of employers. *Id.* at 28, 37-38.

tion 514(a), 29 U.S.C. § 1144(a). *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *summarily aff'd*, 477 U.S. 901 (1986). Congress added "six carefully integrated civil enforcement provisions" which have their own "preemptive force" and provide an "exclusive" federal remedy in suits involving either self-funded or insured plans. ERISA section 502(a), 29 U.S.C. § 1132(a). *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-6 (1987).[8] ERISA thus embodies what this Court recently described as a "'complete pre-emption' doctrine," *Caterpillar Inc. v. Williams*, 107 S. Ct. 2425, 2430 (1987).

The Nevada Supreme Court's decision is at the forefront of a growing number of decisions (*see* citations *infra* at 16-19) that intentionally seek to nullify ERISA's broad coverage and preemption over employee welfare benefit plans by the simple expedient of labeling them "non-ERISA covered." This parochial attempt to resurrect state law as the principal mechanism for regulating these plans contravenes directly this Court's holding in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Furthermore, since over 90% of all plan sponsors are small and medium sized employers who cannot self-fund and are dependent upon group health insurance,[9] these decisions, in essence render ERISA and *Pilot Life* a "dead letter" for over 90% of all employers. Unless the state high court decision is reversed, two of Congress' most important goals in enacting ERISA—broad plan cover-

[8] ERISA's civil enforcement provisions preempt both common law claims, *Pilot Life*, *supra*, and claims based on state insurance codes. *See Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96, 99 (9th Cir. 1988) (as amended in 1989) (*per curiam*); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988); *In Re Life Ins. Co. Of North America*, 857 F.2d 1190 (8th Cir. 1988); *Commercial Life Ins. Co. v. Superior Court*, 47 Cal. 3d 473 (1988).

[9] *Battelle Study* 25, 28, 37-38.

age and preemption, ensuring uniform federal regulation over all plans—will be seriously eroded.

A. *Congress Deliberately Adopted An Expansive Definition Of Employee Welfare Benefit Plan Which The State Court Intentionally Overturned.*

In enacting ERISA, Congress carefully crafted the Act's coverage and preemption provisions to encompass *all* employee welfare benefit plans, self-funded and insured alike. The Nevada Supreme Court's decision, by creating a coverage loophole coextensive with the statute itself, would destroy this important principle of uniformity and permit issues that go to the heart of ERISA's fiduciary standards and civil enforcement provisions to be litigated under state law principles, which include punitive damages.

ERISA section 3(1), the controlling statutory provision, contains an expansive definition of "employee welfare benefit plan" as including "*any* plan, fund, or program . . . established or maintained by an employer . . . providing . . . *through the purchase of insurance or otherwise*, (A) medical, surgical, or hospital care or benefits . . . ." (emphasis added). 29 U.S.C. § 1002(1). Congress, moreover, intended that even this broad "coverage . . . be construed liberally." Senate Rep. No. 93-127 (1973), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4854; House Rep. No. 93-533 (1974), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4639, 4656 (ERISA covers "all private employee benefit plans under Commerce Clause jurisdiction," with stated exceptions); *see also Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984) (as amended in 1985), *cert. denied*, 474 U.S. 865 (1985).

The Department of Labor, the agency responsible for the enforcement of ERISA, has promulgated regulations on section 3(1) providing, in the clearest of terms, that an employer's obtaining of group health care insurance,

and payment of premiums, without more, establishes an ERISA-covered plan.[10] The regulations, which encompass both the direct purchase of insurance and an employer's subscription to a MET, provide that a group insurance plan is ERISA-covered unless there is *no* employer involvement in the plan. 29 C.F.R. § 2510.3-1(j) (1987) lists four specific criteria, all of which must be met, if a plan is to be exempt from ERISA coverage:

> (1) No contributions are made by an employer . . .;
>
> (2) Participation . . . is completely voluntary for employees . . .;
>
> (3) The sole functions of the employer . . . are, without endorsing the program, to permit the insurer to publicize the program to employees . . . [and] to collect premiums and to remit them to the insurer; and
>
> (4) The employer . . . receives no consideration . . . other than reasonable compensation . . . for administrative services actually rendered.[11]

The Bottle Stop's plan was a garden variety employee welfare benefit plan fitting squarely within the statutory definition and the regulations. The overwhelming major-

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[10] Congress specifically empowered the Department of Labor to issue regulations under ERISA, and its construction of the statute, if not in conflict with its express terms, is therefore controlling. ERISA section 505, 29 U.S.C. § 1135. *See Buczynski v. General Motors Corp.*, 616 F.2d 1238, 1242-43 (3d Cir. 1980), *aff'd*, 451 U.S. 504 (1981); *see also Chemical Manufacturers Ass'n v. National Resources Defense Council, Inc.*, 470 U.S. 116, 126 (1985); *Batterton v. Francis*, 432 U.S. 416, 428-429 (1977); 2 K.C. Davis, *Administrative Law Treatise*, Section 7:8 at 36-37 (1979).

[11] If any one of these criteria is not met the plan is ERISA-covered. *See Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96, 98-99 (9th Cir. 1988) (as amended in 1989) (*per curiam*); *Donovan v. Dillingham*, 688 F.2d 1367, 1372-73, 1375 (11th Cir. 1982) (*en banc*); *see also* DOL Opinion Letters 82-059A, 81-84A, 81-73A, 80-10A, and 79-54(A).

ity of employer-sponsored health care plans, which cover over 145 million working Americans and their dependents,[12] are established simply through the purchase of insurance, with employer involvement generally limited to selecting benefits, enrolling participants and paying premiums.[13] Furthermore, claims administration for the overwhelming majority of these insured plans is conducted not by the employer, but rather by an insurer serving as claims review fiduciary under ERISA section 503, 29 U.S.C. § 1133.[14] *See, e.g., LeFebre v. Westinghouse Electric Corp.*, 747 F.2d 197, 203 (4th Cir. 1984); *Schulist v. Blue Cross*, 553 F.Supp. 248, 252 (N.D. Ill. 1982), *aff'd.*, 712 F.2d 1127 (7th Cir. 1983). Far from requiring that plan administration be performed by the employer, ERISA expressly authorizes the allocation of *all* administrative duties without affecting coverage. *See* ERISA section 405(c)(1), 29 U.S.C. § 1105(c)(1); *see also* 29 C.F.R. § 2560.503-1(g)(2) (1987). Indeed, ERISA section 3(16)(A) defines the plan "administrator" as including "(i) the person specifically so designated by . . . the instrument under which the plan is operated [*or*] . . . (ii) if an administrator is not so designated, the plan sponsor. . . ." 29 U.S.C. § 1002(16)(A)(i), (ii).

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[12] *Statistical Abstract of The United States* (108 ed. 1988) 92.

[13] Scallet, *The Regulation of Multiple Employer Trusts: Past, Present & Future*, 61 Wash. U.L.Q. 359, 381 (1983) ("*Regulation of METS*"). *See 1988 Foster Higgins Health Care Benefits Survey* 23 ("*1988 Foster Higgins Survey*") (84% of employers insure their health care plans, or self-fund with stop-less insurance coverage; for employers with less than 1,000 employees, 95% insure such plans or self-fund with stop-loss coverage).

[14] *Regulation of METS* at 381; *Battelle Study* 43. 93% of *all* employers, self-funded and insured alike, use an insurer or third-party administrator for claims administration. *1988 Foster Higgins Survey* 24.

In summary, this is a textbook ERISA case in all respects. The Bottle Stop's plan was plainly covered by ERISA section 3(1), and Turnbow's claims are inseparably intertwined with ERISA's fiduciary standards and civil enforcement provisions in section 404(a), 503 and 502(a). Their eventual determination depends on an examination of the terms of the plan, ERISA's fiduciary responsibility and prohibited transaction rules, and the actual conduct of Petitioners as fiduciaries and parties in interest. In addition, the fiduciary responsibility and prohibited transaction rules are areas of *exclusive* federal court jurisdiction. ERISA section 502(e)(1).

B. *The State Court Decision, By Mandating A Long-Term Duration Requirement, Imposes An Illogical And Unworkable Coverage Standard Which Conflicts With ERISA's Uniform Coverage Provisions.*

Ignoring a common sense reading of the Act, the Nevada Supreme Court held that in order to establish an ERISA-covered plan, an employer must maintain it for a substantial "incubation" period (apparently at least a decade), and cannot terminate it earlier even for business necessity. This most restrictive ruling conflicts with congressional purpose to encompass *all* employee welfare benefit plans as shown by the deliberate breadth of section 3(1), the regulations, and section 89(k) of the Internal Revenue Code.[15] The decision, moreover, creates an illogical and unworkable standard for ERISA coverage which few plans—insured or self-funded—could meet. Only after a substantial span of years can it be determined, retrospectively, whether an employer was sufficiently "committed [to the plan's] continuance" for

[15] Section 89, part of the Tax Reform Act of 1986, mandates that effective plan years beginning in 1989, employee welfare benefit plans must be in writing in order to meet certain qualification standards; it simply requires—in terms of duration—that a plan be "established with the intention of being maintained for an indefinite period of time." 26 U.S.C. § 89(k)(1)(E).

it ever to have been considered ERISA-covered. This standard evidently would strip from ERISA protection *all* non-collectively bargained employee welfare benefit plans set up since 1980.[16]

By simply labeling an employee welfare benefit plan "non-ERISA governed," the Nevada Supreme Court deliberately attempts to upset ERISA's carefully crafted balance between federal and state law, and nullify its coverage and preemption provisions for the vast majority of American health care plans. A dispositive decision by this Court is urgently required to restore the critical balance struck by Congress in ERISA and reaffirm the preeminence of ERISA's civil enforcement remedies over *all* employee welfare benefit plans, self-funded and insured alike.

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[16] The court's decision also conflicts in principle with this Court's decision in *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211 (1987). The majority opinion ruled that ERISA preemption extends to claims under any employee welfare benefit plan (defined as one affording "benefits whose provision by nature requires an ongoing administrative program."). In the Court's view, a one-time severance payment to all employees on closing a plant did not require an employer to face periodic demands on its assets that create a "need for financial coordination and control," and thus require an "ongoing administrative program" to meet the employer's obligations. 107 S. Ct. at 2217-18. The dissenting justices concluded that an "administrative scheme" was not even a pre-requisite for ERISA coverage and preemption. *Id.* at 2224-25. Most significantly, no duration requirement for maintaining a plan at all was set by either the majority or the dissent. In contrast, the employer's establishment of a group insurance plan, and its regular payment of premiums, require the "need for financial coordination and control" found significant in *Fort Halifax*, *supra*, 107 S. Ct. at 2218. Furthermore, insurance benefits, by nature, require an "ongoing administrative program," *id.*, for enrolling new participants, advising them on their rights, and, most importantly, for the processing and review of claims. ERISA sections 3(16)(A)(i), (ii), 405(c)(1), 503; 29 U.S.C. §§ 1002(16)(A), (i), (ii), 1105(c)(1), 1133; 29 C.F.R. § 2560.503-1(g)(2) (1987).

II. The Nevada Supreme Court's Decision, Which Conflicts With The Decisions Of Three Circuits, Reflects An Increasingly Significant Circuit Split, And Wide-Spread Division And Error In The Lower Courts, Which Can Only Be Resolved By This Court.

The Nevada Supreme Court's decision, which conflicts with the decisions of three Circuits, is not an isolated decision. Instead, it reflects an irreconcilable conflict among at least five of the Circuits, and increasing division and error in the lower courts, on ERISA's threshold issues of coverage and preemption.

The state high court drew the essence of its decision from the Fifth Circuit's opinion in *Taggart Corp. v. Life & Health Benefits Admin. Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981). This opinion—like the ones that follow it, including the Nevada decision—shares the fundamental misperception that ERISA coverage depends not on the statutory definition in section 3(1) but on how a plan is funded or administered. *See* Scallet, *The Regulation of Multiple Employer Trusts: Past, Present & Future*, 61 Wash. U.L.Q. 359, 387-88 (1983). ERISA, however, gives an employer *multiple* funding and administration options—including self-funding and performance of all administrative duties by others—without in any way affecting coverage.[17]

Taggart Corp. first held that a MET was not itself an ERISA plan. It then turned to an argument advanced in an *amicus* brief by the Secretary of Labor that ERISA governed the plaintiff's claims because the employer's subscription to the trust created a separate, single-employer ERISA plan. The court rejected this argument based on its assessment that an employer's active performance—as opposed to delegation—of administrative duties was a *sine qua non* for ERISA plan coverage.

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[17] *See* ERISA sections 3(1), 2(16)(A), (i), (ii), 405(c)(i), 503; 29 U.S.C. §§ 1002(1), 1002(16)(A)(i), (ii), 1105(c)(i), 1133; 29 C.F.R. § 2560.503-1(g)(2) (1987); *see also Battelle Study* 37-38.

It consequently ruled that the employer did not establish an ERISA plan because it did not "[participate] in . . . [its] day-to-day operation or administration," and simply paid premiums to a "purveyor of insurance." *Id.* at 1210-11.[18]

Establishing a clear conflict, the Eleventh Circuit in *Donovan v. Dillingham*, 688 F.2d 1367, 1375 (11th Cir. 1982) (*en banc*), expressly disagreed with *Taggart Corp.* Endorsing the Department of Labor regulations, the court held that an individual employer, by subscribing to a MET, can establish its own, single-employer ERISA plan. To determine ERISA coverage, the court applied a four-part test to see whether a decision to extend benefits had become a reality—one must be able to ascertain the "[1] intended benefits, [2] beneficiaries, [3] source of financing, and [4] procedures for securing benefits." It also ruled that the employer's purchase of a group insurance policy "offers *substantial* evidence that a plan . . . has been established." *Id.* at 1373.[19]

The Tenth Circuit noted a "split of authority" a year later in *Roe v. General American Life Ins. Co.*, 712 F.2d 450, 452 (10th Cir. 1983). Citing section 3(1) and *Donovan*, it held that the employer established an ERISA plan by obtaining a group disability insurance policy

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[18] The Seventh Circuit had reached a similar holding in *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 567 F.2d 692, 699 (7th Cir. 1977), where the employer obtained group health insurance for its employees by subscribing through its broker to a MET. The court ruled that the employer did not establish an ERISA plan because it did nothing more than apply for insurance, and pay insurance premiums, and failed to participate in the trust's administration.

[19] More recently, in *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277, 280 (11th Cir. 1987), the Eleventh Circuit held that an ERISA plan existed based on the presence of employer-sponsored group insurance policies. It ruled that "the insurance policies in this case constitute a 'plan' as defined by ERISA. . . ." 833 F.2d at 280.

jointly paid for by the employer and its employees.[20] Also joining the conflict, the Ninth Circuit rejected *Taggart Corp.* in two recent cases involving METs, *Credit Managers Ass'n v. Kennesaw Life and Acc. Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987) and *Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96, 99 (9th Cir. 1988) (as amended in 1989) (*per curiam*). In *Credit Managers Ass'n, supra*, the court, endorsing the regulations, explained that an employer "can establish an ERISA plan rather easily. Even if an employer does no more than arrange for a 'group-type insurance program,' it can establish an ERISA plan, unless it is a mere advertiser who makes *no* contributions on behalf of its employees. 29 C.F.R. § 2510.3-1(j)." 809 F.2d at 625.

A number of other lower federal and state courts, mirroring the sharp Circuit conflict, have recently added to the confusion and error begun by *Taggart Corp.* In *Pitre v. Louisiana Health Service and Indemnity Co.*, 122 F.R.D. 497, 499 (W.D. La. 1988), the district court, finding there was insufficient evidence on premium payment to determine ERISA coverage, nevertheless cited with approval the *Taggart Corp.* coverage requirement that the employer participate in plan administration. In *Sayble v. Blue Cross of Southern California*, 207 Cal. App.3d 953 (1989), the California court of appeal—notwithstanding the Ninth Circuit's clear pronouncements to the contrary—held that an employer's purchase of group health insurance and payment of monthly premiums did not establish an ERISA plan.[21] Overtly hos-

[20] The Third Circuit, in *Shiffler v. Equitable Life Assur. Soc. of U.S.*, 838 F.2d 78, 82 n.4 (3d Cir. 1988), also relying on the regulations, held that even where the employees pay the premiums for group insurance coverage, the plan is ERISA-covered if the employer endorses the plan or is involved in its administration.

[21] Compounding the confusion, the court granted rehearing evidently to resolve whether facts stipulated only to support the defendant's summary judgment motion could be used in support of the plaintiffs' cross-motion. (Order filed March 3, 1989).

tile to ERISA's principal goals, the court wrote that if such plans were ERISA-covered, "every garden variety employee health insurance plan" would be regulated by ERISA, thus "bind[ing] the insured employee to ERISA's remedies." *Id.* at 962. Following the *Taggart Corp.* rationale, the court held that an employer can only establish an ERISA plan by "[participating] in the administration of the . . . insurance benefit" through processing claims and keeping appropriate records to comply with ERISA's reporting requirements. *Id.*[22] *See also Jordan v. Reliable Life Ins. Co.*, 694 F.Supp. 822, 835 (N.D. Ala. 1988) (rejecting ERISA coverage and preemption as overly burdensome; "Only Congress or the Supreme Court can rescue us from the quicksand").

The Nevada Supreme Court's decision is a prime example of increasing division and error in the lower courts on ERISA's most basic issues of coverage and preemption, all stemming from an irreconcilable Circuit conflict. These decisions, to avoid ERISA preemption, overturn the statutory definition of "employee welfare benefit plan," and substitute a coverage test based on how a plan is funded or administered. If these rulings are allowed to prevail, the states will be able to reassert control over essentially all employee welfare benefit plans. In addition, employers will be able to evade ERISA's civil and criminal provisions simply by designating an insurer or a third party as plan administrator. Only a decision by this Court can reassert the uniform system of federal regulation over employee welfare benefit plans that Congress intended and that is now so obviously lacking across the country.

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[22] The California courts of appeal themselves are reaching inconsistent results on the ERISA coverage issue. *See e.g., Rizzi v. Blue Cross of Southern California*, 206 Cal.App.3d 380 (1988) (upholding ERISA coverage based on employer's purchase of insurance and payment of premiums).

III. The Nevada Supreme Court's Decision Takes An Intentional Step Backward From Pilot Life, Reopening A Door To Punitive Damages And Raising Financial Disincentives To Insured Plans Contrary To Congressional Intent.

The Nevada Supreme Court's decision takes an intentional step backward from this Court's recent decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), that ERISA provides an *exclusive* civil enforcement scheme in suits involving employee welfare benefit plans. By effectively repealing these civil enforcement provisions, the decision reopens a door to punitive damages twice closed by this Court in *Pilot Life* and *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985). It also raises financial disincentives to insured plans contrary to congressional intent.

In *Pilot Life* and *Russell*, this Court, after analyses of ERISA's civil enforcement provisions and overall congressional purpose, held that the Act's civil enforcement scheme does not allow for any extracontractual relief, including punitive damages. *Pilot Life*, *supra*, 481 U.S. at 54; *Russell*, *supra*, 473 U.S. at 146. ERISA reflects a "balancing of policies" including the strong "public interest in encouraging the formation of . . . plans." *Pilot Life*, *supra*, 481 U.S. at 54. Congress, in addition, was "acutely aware" that the cost of financing a voluntary system of plans was "an important factor" in determining whether they will be adopted." 120 Cong. Rec. 29,952, 29,953 (1974) (remarks of Sen. Nelson). To promote this voluntary system of plans, Congress placed them all under an umbrella of federal regulation including internal procedures to resolve benefit disputes. *See* ERISA section 503, 29 U.S.C. § 1133. As this Court recognized, a "patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation," leading to a reduction in benefits, or to no plan at all. *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2217 (1987).

The Nevada Supreme Court's decision, by exposing employee welfare benefit plans and their fiduciaries to suits under state law, will lead to increased transaction costs and hence to a reduction in benefits, a self-funding of plans, or to their abandonment altogether.[23] This sharply clashes with Congress' intent as shown in section 89 of the Internal Revenue Code to expand the use of employer-sponsored health care plans to provide for the "well-being and security" [24] of the over 30 million Americans (one out of eight) without any coverage at all.[25]

IV. The Court's Alternative Holding That Working Owners Are Not Participants Or Beneficiaries For Purposes Of ERISA's Civil Enforcement Provisions Creates A Serious Dysfunction In The Statute, And Will Lead To The "Mutually Exclusive Pockets Of Federal And State Jurisdiction Within A Plan" Warned Against By This Court.

In its alternative holding, the Nevada Supreme Court addressed a second, major ERISA issue—whether working owners, partners or sole proprietors who, along with common law employees,[26] are covered by an ERISA plan, are "participants" or "beneficiaries" for purposes of ERISA's civil enforcement provisions. ERISA defines "participant" as the "employee" of any employer, and defines "beneficiary" as including "a person designated . . . by the terms of [a] plan, who is or may become eligible to receive benefits. . . ." [27]

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[23] *See amicus* brief filed by the Solicitor General, on behalf of the United States, at 7-8, in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

[24] *See* ERISA section 2(a), 29 U.S.C. § 1001(a).

[25] *Statistical Abstract of the United States* (108th ed. 1988) 92.

[26] An ERISA plan must include at least *one* common law employee; if the only participants are owners, partners or sole proprietors there is no ERISA coverage. 29 C.F.R. § 2510.3-3(b) (1987); *see* DOL Opinion Letter 77-10.

Inclusion of these self-employed individuals in employee welfare benefit plans along with common law employees has long been standard practice—indeed, one approved by the National Association of Insurance Commissioners.[28] ERISA, moreover, covers the self-employed in its other regulatory provisions which govern participation and vesting, funding, fiduciary responsibility, and reporting and disclosure.[29] Congress most recently reconfirmed

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[27] ERISA defines a "participant" as "any employee of an employer . . . who is or may become eligible to receive a benefit . . . from an employee benefit plan. . . ." Section 3(7), 29 U.S.C. § 1002(7). "Beneficiary" is defined in Section 3(8), 29 U.S.C. § 1002(8).

[28] *See* N.A.I.C. Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act, Section 1 (eligible employees may include the employees of the employer's subsidiaries as well as an individual proprietor and partners of a partnership); Harnett and Lesnick, *The Law of Life and Health Insurance* (1988) § 9.01 [3]. *See also* Gregg, *Group Life Insurance* (1957 ed.) 28 ("Individual proprietors and partners are generally considered to be employees for group insurance purposes if they are actually engaged in the business.")

[29] *See* ERISA sections 101-111, 201-211, 401-414, 301-306, 29 U.S.C. §§ 1021-31, 1051-61, 1101-14, 1081-86; *see also* Department of Treasury, Department of Labor, and Pension Benefit Guaranty Corporation 1987 Instructions for Form 5500-C, No. 7 ("Active participants include any individuals who are currently in employment *(including self-employed)* covered by a plan and who are earning or retaining credited service under a plan" (emphasis added). As shown in the discussion of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and section 89 of the Internal Revenue Code, *infra*, Congress has consistently used the term "employee" in its broadest sense to include the working self-employed when both the self-employed and common law employees are covered by a welfare benefit plan. This reflects the common understanding of the term in the group insurance context. *See* Gregg, *Group Life Insurance* (1957 ed.) 28; Greider and Beadles, *Law and The Life Insurance Contract* (4th ed. 1979) 581. The Department of Labor regulations, by describing self-employed individuals as "participants," also demonstrate that where an ERISA plan covers both the self-employed and common law em-

its intent to include the working self-employed as ERISA "participants" and "beneficiaries" in its enactment of the satellite statute, COBRA, and section 89 of the Internal Revenue Code.[30]

At stake is whether suits by the self-employed for plan benefits and breaches of fiduciary duties will be governed by ERISA or by conflicting state law doctrines. This issue is one of extraordinary breadth over which

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ployees, the Act governs the rights of all participants. 29 C.F.R. § 2510.3-3(b) (1987). *See* DOL Reporting and Disclosure Regulations, 40 Fed. Reg. 34525, 34528 (August 15, 1975) (definition of "employee" in 29 C.F.R. § 2510.3-3 is for the limited purpose of determining whether a plan has any employees, and thus whether an ERISA plan exists; hence the regulations are revised to expressly limit the definition of "employee" to § 2510.3-3 in order to avoid excluding the "self-employed" from the definition of "participant" in ERISA section 3(7)). *See also* DOL Opinion Letters 79-8A and 81-54A; *Dodd v. John Hancock Mutual Life Ins. Co.*, 688 F.Supp. 564, 571-72 (E.D. Cal. 1988); *see also Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 740 n.14 (7th Cir. 1986), *cert. denied*, 107 S. Ct. 3188 (1987). In contrast, a sole proprietor who brings no covered employees to a union-sponsored health care plan is not an ERISA "participant." *Giardono v. Jones*, 1989 U.S. App. LEXIS 1499 (7th Cir., 1989) (the court erred, however, in assuming the restrictive definition of "employee" in § 2510.3-3 was intended to carry over to ERISA section 3(7)).

[30] Under COBRA, the working self-employed who are covered by group health care plans which include common law employees are treated as "participants" and "covered employees" entitled to the full spectrum of COBRA continuation requirements. *See* Proposed Treas. Reg. § 1.61-1 Q & A 16 (1987). Similarly, section 89, 26 U.S.C. § 89, includes 5% owners as "participants" and "highly compensated employees" under all of its nondiscrimination rules for group health care plans; these individuals must be treated as "participants" and "employees" on a non-discriminatory basis with "non-highly compensated" employees. Furthermore, both COBRA and section 89 encourage employers to consolidate and centralize plan administration through the use of a single benefit structure for all individuals covered by group health care plans. Kelly, *How will The Welfare Benefit Plan Nondiscrimination Rules Apply?*, The Journal of Taxation, August, 1988, 80-81.

the courts are reaching conflicting results.[31] It affects every business in which a self-employed individual, along with one or more common law employees, is covered by and eligible to receive benefits under an ERISA plan. This includes not only medical, accounting and legal partnerships and professional corporations nationwide, but also many hundreds of thousands of small and medium sized businesses across the country whether incorporated or not.

The Nevada Supreme Court, by excluding the working self-employed from ERISA's civil enforcement provisions, creates a serious dysfunction between ERISA's civil enforcement scheme and the rest of its regulatory provisions. This schism, moreover, will permit the individual participant to sue the plan fiduciaries, who are required to administer the entire plan in accordance with federal law, for alleged violations of state law—the very conflict that *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), was intended to resolve. The state high court's decision also undercuts Congress' central purpose of promoting a cost-effective private employee benefit plan system through uniform fiduciary standards and remedies to guard individual rights from administrative abuse, and a single regulatory framework to allow simplicity and "national uniformity" in plan administration, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 n. 20 (1983). Only the inclusion of working owners in ERISA's civil enforcement provisions will advance these important goals. It will ensure that all working individuals covered by ERISA plans be protected by exactly the same fiduciary standards and remedies regardless of whether a pension

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[31] *Compare Dodd v. John Hancock Mutual Life Ins. Co.*, 688 F.Supp. 564, 571-72 (E.D. Cal. 1988) (sole owner of corporation is employee participant under ERISA) with *Pitre v. Louisiana Health Service and Indemnity Co.*, 122 F.R.D. 497, 499 (W.D. La. 1988) (law firm partner is not participant under ERISA).

or welfare benefit plan is involved.[32] It will also make certain that all ERISA plans be administered under a uniform set of procedures governed by a single set of laws. *See Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2217 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 107-08 (1983).

In summary, the Nevada Supreme Court's decision creates the "mutually exclusive pockets of federal and state jurisdiction within a plan," and the "conflicting and inconsistent State and local regulation" against which this Court warned in *Fort Halifax*, *supra*, 107 S. Ct. at 2217, and *Shaw*, *supra*, 463 U.S. at 99, 107-08 (1983). If the decision is permitted to stand, Petitioners will be required to process Turnbow's benefit claims under state law, and the claims of all other participants under federal law—even if these laws require different results and impose vastly different remedies. Furthermore, to allow state law to govern Turnbow's claim of excessive premium

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[32] In a qualified retirement plan, ERISA treats self-employed individuals as employees for substantially all plan purposes, including participation. Any disparate treatment of self-employed individuals and common law employees between Title I (Protection of Employee Benefit Rights) and Title II (Amendments to the Internal Revenue Code Relating to Retirement Plans) of ERISA is plainly unwarranted in light of the fact that some plans are *both* welfare and pension plans (*see* ERISA section 3(3)), Congress' enactment of COBRA and Internal Revenue Code section 89, discussed *supra*, and its recognition of the need for "parity" between corporate and noncorporate plans reflected in the Tax Equity and Fiscal Responsibility Act of 1984 ("TEFRA"). *See RIA Employment Coordinator*, ¶ B-10,103 (Current Matter, Jan. 1989); Treas. Reg. § 1.162-26, Q & A 16 (1987); S. Rep. No. 494, 97th Cong., 2d Sess. 314, *reprinted in* 1982 U.S. Code Cong. & Admin. News 781, 1055; H. Con. Rep. No. 760, 97th Cong., 2d Sess. 620, *reprinted in* 1982 U.S. Code Cong. & Admin. News 1190, 1392. This Court, moreover, in construing ERISA's civil enforcement provisions recently disapproved of distinctions between funded and unfunded plans, at least with respect to the appropriate standard of judicial review of benefit determinations, in *Firestone Tire and Rubber Co. v. Bruch*, 57 U.S.L.W. 4194, 4198 (1989).

charges will not only cause an irreconcilable federal-state conflict over premium levels for the plan as a whole, but will permit the states to usurp the federal court's exclusive jurisdiction over ERISA's fiduciary standards and prohibited transaction rules. Such multiplicity of regulation and open-ended administrative and financial burdens were precisely the problems that ERISA was intended to avoid. *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2217 (1987).

Review of the Nevada Supreme Court's decision is essential to resolve the pervasive and unsettled issues of "participant" and "beneficiary" status. Failure to do so now will only add to the statutory dysfunction, and the "mutually exclusive pockets" of federal and state jurisdiction and "conflicting and inconsistent . . . regulation" proscribed in *Fort Halifax*, *supra*, and *Shaw*, *supra*.

V. The Questions Presented By This Petition Hold Important Implications For Employee Welfare Benefit Plans That Should Be Resolved By This Court.

The Nevada Supreme Court's decision undoubtedly poses a serious threat to Congress' twin goals of broad ERISA plan coverage and preemption, goals designed to encourage the growth and development of a private system of employee welfare benefit plans.

Over 145 million working Americans and their dependents are covered by employer or union-sponsored health care plans.[33] Moreover, of the estimated 4.5 million employer-sponsored health care plans,[34] the overwhelming majority are insured plans of the garden variety type. A recent study shows that 84% of employer-

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[33] *Statistical Abstract of the United States* (108th ed. 1988) 92.

[34] *Administration of the Employee Retirement Income Security Act, Calendar Year 1987, Report of the Secretary of Labor to Congress* i.

sponsored health care plans are insured or are self-funded with stop-loss coverage; for smaller employers, the figure rises to 95%.[35] Furthermore, 93% of *all* employers, self-funded and insured alike, delegate claims administration to an insurer or third-party administrator.[36]

The sponsors and administrators of these employee welfare benefit plans are required to make decisions on a daily basis regarding the continued existence of plans, the source of funding, the allocation of administrative duties, compliance with federal and state laws, "participant" and "beneficiary" coverage, and the processing and payment of claims. These decisions affect literally tens of millions of participants and beneficiaries. In addition, many of these plans are administered on a multi-state basis.

A dispositive decision by this Court is necessary to give practical guidance to sponsors and administrators on two of the most fundamental but increasingly unsettled ERISA issues—what is an "employee welfare benefit plan," and whether working owners, if covered by ERISA plans, are "participants" and "beneficiaries" for civil enforcement purposes. As shown by the sharp Circuit division and conflicting lower court cases, swift intervention by this Court is essential to restore Congress' carefully crafted balance between federal and state law, and to reestablish ERISA's preeminence over *all* employee welfare benefit plans.

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[35] *1988 Foster Higgins Survey* 23. *See also Battelle Study* 44 (99% of small employer health care plans (fewer than 100 employees) are insured; 92% of large plans (100 or more employees) are insured).

[36] *1988 Foster Higgins Survey* 24. Even for employers who self-fund their health care plans, 89% delegate claims administration. *Id. See also Battelle Study* 44 (99% of small employer health care plans, and 92% of large employer plans, delegate claims administration to an insurer).

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the judgment and opinion of the Nevada Supreme Court.

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